

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County _____ Registration District No. **791**
 Township _____ Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **1424**) **Madison**

File No. **15662**
 Registered No. **4098**
 St. _____ Ward _____

2. FULL NAME

Catherine Leskey
 (a) Residence, No. **1424** **Madison** St., **26** Ward. _____
 (Usual place of abode) _____ (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles N. Leskey		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 20, 1866		
7. AGE	YEARS 65	MONTHS 2
	DAYS 12	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Nursework (b) General nature of industry, business, or establishment in which employed (or employer) 235 (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland		
PARENTS	10. NAME OF FATHER John Nahn	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland	
	12. MAIDEN NAME OF MOTHER Margaret M. Namee	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland		

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 2nd, 1931**

17. I HEREBY CERTIFY, That I attended deceased from **Much** **15th**, 19**31**, to **April 2**, 19**31** that I last saw h. w. alive on **April 1st**, 19**31**, and that death occurred, on the date stated above, at **2 22 a. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia (Lobar)
59
108
131 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) **Diabetes Mellitus + Chronic Nephritis** (duration) **4** yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Laboratory + Physical Findings**
 (Signed) **W. J. Glavin** _____ M. D.
4-2 .1931 (Address) **5738 W. Florissant**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address) James Leskey 1424 Madison St.	19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery	DATE OF BURIAL 4/6/1931
15. FILED 15 1 19 W. J. Glavin REGISTRAR	20. UNDERTAKER Bergesch Mfg Co. 3661 Washington	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

